CHDP Medical Record Reviewer Guidelines

Rationale: A well-organized medical record keeping system permits effective and confidential client care and quality review.

1. Format Criteria	Medical Record Reviewer Guidelines - Format
A. An individual medical record is established for each family member.	Providers must be able to readily identify each client treated. A medical record shall be started upon the initial visit for each client. "Family Charts" are not acceptable.
B. Client identification is on each page.	Client identification shall include first and last name, and/or a unique client number established for use at the clinical site.
C. Individual personal biographical information is documented.	Personal biographical information includes: date of birth, current address, home/work phone numbers, and name of parents, if client is a minor. If portions of the personal biographical information are not completed, reviewers should attempt to determine if client has refused to provide information. Do not deduct points if client has not provided all personal information requested by the provider.
D. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person shall be identified for all clients. If the client is a minor, the contact person must be a parent or legal guardian. Emancipated minors and adults may list anyone they so choose. Do not deduct points if client has not provided personal information requested by the provider.
E. Each medical record on site is consistently organized.	Contents and format of printed and/or electronic records within the practice site are uniformly organized.
F. Chart contents are securely fastened.	Printed chart contents must be fastened or bound to prevent medical record loss.
G. Notice of Privacy Practices	Signed form or sticker needs to be present in chart identifying the parent received a copy of the privacy notice

Rationale: Well-documented medical records facilitate communication and coordination, and promote the efficiency and effectiveness of treatment.

2. Documentation Criteria	Medical Record Reviewer Guidelines - Documentation
A. Allergies and adverse reactions are prominently noted.	Allergies and adverse reactions must be listed in a consistent location in the medical record. If client has no allergies/adverse reactions, "No Known Allergies" (NKA) OR "No Known Drug Allergies" (NKDA) must be documented.
B. Health-related conditions are identified (e.g., problem list)	Chronic conditions include current long-term, on-going problems with slow progress or little progress (e.g., hypertension, depression, diabetes). Documentation can be on a separate problem list or listed in the progress notes.
C. Current continuous medications are listed.	The list of current, on-going medications must include medication name, strength, dosage, route, start/stop dates. Documentation can be on a separate problem list or listed in the progress notes.
D. Appropriate consents are present (in record) when appropriate.	Written consents must be signed for operative and invasive procedures, all contraceptive methods, human sterilization, and release of medical information. The parent/legal guardian of a minor may sign a written consent form for medical care. Each chart will have a signed and dated consent for treatment. If the client is a minor, a legal parent or guardian will have signed the consent for treatment.
E. Errors are corrected according to legal medical documentation standards.	Persons making a documentation error must correct it by drawing a single line through the error, writing "error" above/near the lined-through entry, writing the corrected information, and signing the entry. Erasing and/or use of correction fluid is not acceptable.
F. All entries are signed, co-signed, if applicable, dated and legible.	Signature includes the first initial, last name, and title. Stamped signatures are acceptable, but must be authenticated. Methods used to authenticate signatures in electronic medical records are dependent upon computerized system used on site, and must be individually evaluated by reviewers. Date includes the month/day/year. Physician's assistants must have a co-signature by a physician as required by California law.
G. Copy of pre-enrollment application.	Must be presented when requested by the State.

Rationale: The medical record promotes "seamless" continuity-of-care by communicating the client's past and current health status and medical treatment, and future health care plans.

3. Coordination and Continuity-of-Care Criteria	Medical Record Reviewer Guidelines – Coordination and Continuity of Care
A/B. Comprehensive health history, including family history is done.	A comprehensive health history should include the following information for all clients: family/social history, serious accidents, diseases, and surgeries. Pediatric histories should include past prenatal and birth history, growth and development, and childhood illnesses. For clients aged 14 years and above, the past history includes past and current sexual history and tobacco, alcohol, and substance use. An update to the Health History and Review of Systems is documented at each periodic visit.
C. Initial/Annual review of systems are documented.	Review of systems is documented at each periodic visit.
D. Evidence of appropriate exam is documented.	A complete physical exam – unclothed – is documented at each periodic visit. Each visit has a documented diagnosis or impression and is based on an age appropriate physical exam, or stated chief complaint or reason for the visit based on client interview. Note: Charts of comprehensive care providers shall have evidence of episodic care.
E. Treatment plans are consistent with diagnoses.	Treatment and/or action plan is documented for each diagnosis, and relates to the stated diagnosis.
F. Client and/or primary caregiver received instructions for follow-up care.	Specific follow-up instructions, along with a definitive time for return visit or other follow-up care is documented. Time period for return visits and/or other follow-up care is definitively stated in number of days, weeks, months, etc., or as needed.
G. Unresolved and/or continuing problems are addressed in subsequent visits.	Documentation shows that unresolved and/or chronic problems are assessed at subsequent visits. All problems need not be addressed at every visit. Reviewer should be able to determine if provider follows up with client about treatment regimens, recommendations, counseling, and referrals.
H. Consultation, referral, and diagnostic test reports are completed.	Medical record contains consultation reports and diagnostic test results for requests ordered. There is documented evidence of review by the examiner.
I. Test results/diagnostic reports and discussion with client have explicit notation in record. Abnormal reports are reviewed and documented.	A physician must review all reports with evidence in medical record of follow-up with the client. Record includes notation about client contact or attempted contacts, follow-up treatment and/or instruction provided, and return. Diagnostic (e.g., lab, x-ray) test reports, consultation summaries, inpatient discharge records, emergency and urgent care records must have evidence of review by a physician. Evidence of review may be the physician's initials or signature on the report/record, or a notation in the progress note by physician.
J. Missed appointments and follow-up actions are documented.	Documentation includes incidents of missed appointments and/or examinations. Attempts to contact the client and/or parent/guardian (if minor), and the results of follow-up actions are also documented in the record.

Rationale: The medical record promotes "seamless" continuity-of-care by communicating the client's past and current health status and medical treatment, and future health care plans.

4. Pediatric Preventive Criteria	Medical Record Reviewer Guidelines – Pediatric Preventive
A. Initial health assessment and periodic health assessments are completed and recorded on a PM 160.	**Initial and periodic health assessments** are completed according to CHDP periodicity. Initial and periodic health assessments shall have nutrition, dental, health education/anticipatory guidance, developmental and tobacco assessments and guidance. CHDP Program pediatric preventive physical examinations are completed at each health assessment visit and include: (1) review of systems and interval histories as appropriate; (2) anthropometric measurements of weight and length/height, and head circumference of infants up to age 24 months; (3) physical examination/body inspection, including screening for sexually transmitted diseases (STD's) of sexually active adolescents. Assessments are appropriately recorded on Confidential Screening/Billing Report (PM 160) forms, with identified problems documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate. **Nutritional Assessment** requirement includes: (1) anthropometric measurements; (2) laboratory test to screen for anemia (hematocrit or hemoglobin); and (3) breastfeeding/infant formula intake status, food/nutrient intake, and eating habits. Based on problems/conditions identified in the nutritional assessment, reviewers should look for referral of nutritionally at-risk children under five years of age to the Women, Infants and Children (WIC) Supplemental Nutrition Program, or for medical nutrition therapy and/or other in-depth nutritional assessment as appropriate. **Dental Assessment** includes an inspection of the mouth, teeth, and gums at every health assessment visit. Children are referred to a dentist at any age if a dental problem is detected or suspected. **Behavioral Assessment** includes an age appropriate and culturally sensitive socio-emotional/behavioral history and screening at each health assessment visit. Integrate information from the health history and physical examination to determine whether the child's development and behavior falls within a normal range according to age group and cultural background. **Health Education/Anticipatory Guidance** is provided at each health assessment visit. This includes providing or referring to counseling, and providing appropriate, specifically related educational materials. Identified problems and interventions (nutrition counseling, parenting classes, smoking cessation programs, etc.) are addressed in the progress notes. **Developmental Assessment** – refer to Health Assessment Guidelines for standards. List screening tool if used. **Tobacco Assessment** – refer to Health Assessment Guidelines for standards.
B/C. Development and Behavioral Screening Tools.	Children with developmental or behavioral risks should be promptly addressed using a standardized screening tool to identify and refine a recognized risk. Indicate the standardized tool the provider uses.
D. Vision screening (Snellen test or equivalent) is completed.	Vision screening is completed with results according to CHDP periodicity. Screening for visual problems should occur at each health assessment visit and results should be documented in the record or on the PM 160. Vision screening for infants and children from birth to three years of age consists of a red reflex examination, corneal penlight evaluation, and an external eye inspection. The picture recognition posters or Snellen "tumbling E" charts are recommended for children from three to six years of age, and Snellen letter

4. Pediatric Preventive Criteria	Medical Record Reviewer Guidelines – Pediatric Preventive
	charts for children over age six years. The method used for visual screening varies depending on the age, maturity, and language development level of the child. CHDP recommends that any child unable to be tested after two attempts or in whom an abnormality is detected be referred for an initial eye evaluation by an optometrist/ophthalmologist experienced in the care of children. Referral to an optometrist or ophthalmologist is provided as appropriate.
E. Hearing screening is completed.	The American Academy of Pediatrics (AAP) recommends initial newborn hearing screening prior to discharge from the delivery hospital or by approximately one month of age. The CHDP assessment for hearing problems includes non-audiometric screening for infants and children from two months through two years of age. Non-audiometric screening may include an assessment of speech and language development, a family and medical history, parental concerns, physical examination, and use of measured noisemaker or sound generators. Audiometric screening is done on children and young adults from age 3-20 years at each health assessment visit and the results documented in the medical record or on the PM 160. Failed audiometric screenings are followed up with a repeat screening. Children who fail to respond on two screenings separated by an interval of at least two weeks and no later then six weeks after the initial screening are referred to a specialist. Follow-up care or referral to specialist is provided as appropriate.
F. WIC Referral.	Infants and children younger than 5 years of age may be eligible for the Women, Infants, and Children (WIC) Supplemental Nutrition Program and should be referred appropriately.
G. Fluoride Use.	Providers are required to prescribe a fluoride supplement if drinking water is not adequately fluoridated.
H. CHDP lab work is present. **Other testing is completed as appropriate for age.**	Each child has a hemoglobin (Hgb) or hematocrit (Hct), urine for dipstick or analysis, and other lab as appropriate for age and according to the CHDP periodicity schedule. Urine is tested at each health assessment visit starting at age four to five years. Pap smears, Chlamydia testing, or other sexually transmitted disease (STD) testing is performed as appropriate for age.
I. Lead counseling and testing are completed.	Follow the current lead protocol in Health Assessment Guidelines for CHDP. Follow-up care or referral to specialist is provided as appropriate.
J. TB risk assessment and/or tuberculin skin test is completed.	The Mantoux skin test is administered at the health assessment according to the CHDP periodicity schedule. However, all children are screened for risk of exposure to tuberculosis (TB) at **each** health assessment visit. The Mantoux skin test is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. The Mantoux test is not administered if the child has had a previously documented positive Mantoux skin test. The skin test is read by trained personnel 48-72 hours after administration, and is recorded in millimeters (mm) of induration. See the Health Assessment Guidelines for induration definition. Children with positive reactions receive follow-up medical evaluation, chest x-ray, and other needed diagnostic laboratory studies, or referral to specialist as appropriate.
K. Childhood immunizations are up-to-date.	There is a consolidated immunization record present. Immunization registry summary is acceptable. Immunization status is assessed at each health assessment visit and during each encounter. All needed

4. Pediatric Preventive Criteria	Medical Record Reviewer Guidelines – Pediatric Preventive
Immunization history and record are present. Immunization log meets VFC requirements.	Vaccines are administered according to guidelines established by the Public Health Service Advisory Committee on Immunization Practices (ACIP), unless medically contraindicated or refused by the parent. For each vaccine, the manufacturer and lot number is recorded in the medical record. Documentation of receipt of VIS exists including date of VIS. Generally found on the Immunization Administrative Sheet. A history of immunizations received and a copy of the current immunization records should be in the chart. The immunization Log must have the elements required by the Vaccines for Children (VFC) Program.
L. If Health Assessment Only Provider, child/client is referred to a medical and dental home. Or **If Comprehensive Health Provider, referred client to a dental home.**	Health Assessment Only providers have documented a referral to both a medical and dental provider. Beginning at age three years, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected. If a Comprehensive Health Care Provider, the examiner has made an annual referral to a dentist regardless of whether a dental problem is detected or suspected. Dental exams are now recommended at age 1 year. Referral is required at age 3 years.
M. Appropriate growth measurements are taken and plotted at each visit.	When appropriate for age, each child/client under the age of two has a head circumference taken and plotted on a growth chart. Each child/client over the age of two has a length/height and weight taken and plotted at each visit. For children over the age of two, Body Mass Index (BMI) percentile is determined and plotted on the appropriate Center for Disease Control (CDC) growth chart.
N. Blood pressure is measured at each visit as appropriate for age.	Blood pressure (BP) is measured and recorded at each visit starting at three years of age. If hypertension (BP ≥ 95th percentile for age and sex) is suspected, the child's position, limb, and cuff size are documented in the medical record. The BP measurement is repeated if ≥ the 90th percentile for age and sex. Refer to Health Assessment Guidelines for current standards.
O. Reporting health assessment results on statewide report form (Confidential Screening/Billing Report PM 160) concurs with documentation in the client's medical record.	The findings of the health assessment are recorded in the client's medical record and are reported on the statewide report form known as the Confidential Screening/Billing Report (PM 160). The findings recorded and reported are the same for the date of service.